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ABSTRACT

Changes in the population of children served as educable mentally retarded (EMR) in the public schools are examined. The term "new" refers to children currently classified as EMR, in contrast to children classified as EMR in the late 1960s, predating court actions challenging the criteria for EMR eligibility. "New" EMRs have an IQ of 50-75, while the former IQ cutoff was 85. Prevalence rates have been higher for certain ethnic minority groups, such as blacks and Hispanics. It was felt by some that disproportionate enrollments were due to the discriminatory nature of the intelligence tests administered. Despite the reduction in the total number of children classified as EMR, the definition change had relatively little impact on ethnic disproportion. The average ability level of EMR children today is lower than it was prior to the revision, and many empirical and philosophical questions need to be answered concerning the best content and setting for their educational programs. The marginal learners, who were decertified as EMR, became enrolled in regular classes and received no special education services; they now find themselves ill-prepared to meet minimum competency standards required for graduation. Little improvement has occurred in the quality of education received by these students. (JDD)

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Chapter One

"New" EMRs

Donald L. MacMillan

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OVERVIEW

In this chapter changes in the population of children served as educable mentally retarded (EMR) in the public schools is examined. The use of the word "new" in the title should not be interpreted to suggest that a unique group of children, unlike those previously served, is currently populating the EMR programs. Rather, the evidence suggests that those currently enrolled tend to resemble a subset of the former group and indicates that some children resembling higher functioning trainable mentally retarded (TMR) have found their way into EMR programs (Polloway & Smith, 1983).

It is important to realize that the public schools have long served students representing a wide range of individual differences. For example, students differ in terms of age, gender, race, social class, achievement, and ability. Over the years the public schools have differentiated students according to ability by providing programs for the mentally retarded and gifted, reflecting the belief that differential education is needed for children who deviate markedly from the norm. Operationalizing what constitutes marked deviation has posed problems; that is, determining just how far up or down the intellectual continuum a child must score in order to warrant or necessitate special educational adaptations has been problematic.

The issue addressed in this chapter concerns the vacillation in setting criteria for defining those children whose low academic achievement in regular programs is due to low general intellectual functioning (as opposed, say, to a specific learning disability or emotional problem). Such children are classified as mentally retarded by school personnel, and provided special education. In the context of this chapter, the term "new" is used in reference to children currently classified as EMR, while the term "old" refers to those children classified as EMR in the late 1960s, predating court actions (e.g., Diana v. State Board of Education, 1970; Larry P. v. J. Wilson Riles, 1971) challenging the criteria for EMR eligibility.

Before considering these forces which changed the criteria for EMR eligibility let us consider mental retardation in the broader context, and what is meant by a child who is educably mentally retarded.

Definitions

In 1961, the American Association on Mental Deficiency proposed the following definition of mental retardation:

> Mental retardation refers to subaverage general intellectual functioning which originates in the developmental period and is associated with impairment in adaptive behavior. (Heber, 1961, p. 3)

This definition operationalized the upper cut-off for mental retardation to be approximately IQ 85, and constituted an "inclusive" definition of mental retardation, making sure virtually no child was denied services who might benefit from them.

As a result of professional criticism (e.g., Dunn, 1968), court action (e.g., Diana, 1970; Larry P., 1971), and socio-political concerns over the disproportionately high minority enrollments in EMR classes, the AAMD revised its definition of mental

retardation in 1973 (Grossman, 1973). Further minor revisions occurred in 1977 and 1983. The current definition of mental retardation supported by the AAMD is as follows:

> Mental retardation refers to significantly subaverage general intellectual functioning resulting in or associated with impairments in adaptive behavior and manifested during the developmental period. (Grossman, 1983, p. 1)

Operationally, the 1983 definition sets the upper IQ limit for mental retardation at 70, but emphasizes that this is to be used as a guideline only (i.e., not an absolute standard), and that IQ scores up to 75 could still qualify, especially in school settings, if clinical judgment leads to the conclusion that impaired adaptive behavior is caused by deficits in judgment and reasoning.

The AAMD recognizes that all individuals who qualify for services as mentally retarded are not alike. That is, there is considerable variability in the problems presented by those categorized as mentally retarded. In order to cope with this diversity, the AAMD classifies within the mentally retarded population according to IQ levels. Cases where the IQ falls between 50-75 are classified as "mildly mentally retarded", those between 35-50 as "moderately mentally retarded", those between 20-35 as "severely mentally retarded," and those functioning below 20 as "profoundly mentally retarded." The reader should note that the AAMD classification scheme only roughly approximates the most commonly used educational classification scheme. While both classify by degree of mental retardation, educators have not traditionally used specific IQ cut-offs, but rather assessments of the best match between a child's functioning level and the program offerings. Furthermore, the terms used by educators are not the same. Educators term the higher functioning children as "educable mentally retarded" (or some similar term, e.g., educable mentally handicapped), the next level of children as "trainable mentally retarded", and then the lowest functioning group as "severely handicapped" or some similar term.

Prevalence of Mild Mental Retardation

Prevalence is a term which refers to the total number of cases of a condition at a particular point in time. In the context of mental retardation, prevalence refers to the number of people (or the percent of a population) classified as mentally retarded at any point in time. Prior to the court cases noted above, legislation, and changes to a more restrictive definition, the evidence suggested an overall prevalence rate of mental retardation (for all ages, birth through old-age) hovering around one percent of the total population (Birch, Richardson, Baird, Horobin, & Illsey 1970; Mercer, 1973). However, the prevalence rates varied by age, sex, socioeconomic status, and degree of retardation (MacMillan 1982). In an effort to determine what portion of all cases classified as mentally retarded are "mildly retarded" one can deduct those cases of severe retardation - known to exist at a rather stable rate.

Abramowicz and Richardson (1975) used IQ 50 as the upper limit for defining severe mental retardation. Using this figure as a criterion, they examined a number of studies, and wrote:

> A review of twenty-seven epidemiological studies, nineteen of which may be considered to have reliable prevalence data on severe mental

> retardation in older children, shows a remarkable consistency in the prevalence of severe mental retardation in children, which approximates 4 per 1000. (p. 37)

Using an upper limit of IQ 35 (consistent with the AAMD classification scheme), Eyman and Miller (1978) estimated that prevalence to be 1.3 percent of the population are classified as severely or profoundly mentally retarded. Given the traditional use of IQ 50 to differentiate those cases of mental retardation due to biomedical causes and those for which no biomedical cause can be identified, we will use the Abramowicz and Richardson (1975) figure of 0.4% in the following estimates.

The reduction in overall rates of mental retardation between 1970 and the present has been noted by many (e.g., Forness, 1985; Lambert, 1981; MacMillan & Borthwick, 1980; Polloway & Epstein, 1985; Polloway & Smith, 1983). This reduction in the prevalence of mental retardation has not resulted from any significant change in the rate for severe and profound retardation, and probably not in cases of moderate retardation. Rather, this reduction in numbers is, in large part, due to dramatic change in cases of mild mental retardation - that segment that largely populated EMR classes in 1970. In California, for example, a mandated reassessment of all EMR students using different criteria (i.e., different IQ cut-offs and weighting nonverbal portions of the test heavily) resulted in the decertification of between 11,000 and 14,000 EMR students in the early 1970s. States adopting the revised AAMD definition with its lower IQ cut-off immediately made ineligible those students with IQs in the range of 70-85 from receiving services. In other words, by changing the definition of mental retardation and the criteria for eligibility, states "cured" mental retardation in a substantial number of cases, although as MacMillan (1982) noted, "...learning problems cannot be mandated or legislated away" (p. 18). What was accomplished, however, was that this segment of children (i.e., IQ 70-85 with general learning problems) would not be eligible for services as students with mental retardation.

Polloway and Smith (1983) reported federal data on the number of retarded children served by the public schools in the various states between 1976-77 school year and 1980-81. During this period, the nationwide decrease in the percentage of students served as mentally retarded was 12.9%. Twenty states and the District of Columbia decreased in the percent of mentally retarded students by 20% or more. Conversely, several southeastern states reported increased rates during this period (Alabama, Arkansas, Mississippi) between 10-20%. As will be discussed later, variability between states is the rule rather than the exception. Furthermore, California reported only a 9.2% reduction during this time frame, probably because of the change in policies resulting from Diana, which served to reduce EMR enrollments well before 1976-77.

Forness (1985) also examined federal data reflecting the decrease in mental retardation and the increase in learning disabilities during a five-year period (1976-77 to 1981-82). While the number of school children classified as mentally retarded decreased from 970,000 to 802,000 (a 17% reduction), the number of LD children increased from 797,000 to 1,627,000 (a 104% increase). The 1976-77 school year provides a baseline figure representing a time before P.L. 94-142 was operational to any degree, while 1981-82 represents the year at which the law was intended to be fully operational for all handicapped children, aged 3-21.

Table 1 shows the steady decline in the percent of children classified as mentally retarded and the corresponding increase in the prevalence of learning disabilities between the 1976-77 school year and the present. The reduction in the percent of mentally retarded students is due largely, if not exclusively, to shifts in defining mental retardation as a more exclusive concept. However, it should be noted that the magnitude of the change in prevalence of mental retardation reflected in these national figures tends to obscure the variability in rates among states. Table 2 shows the most recent state figures showing the percent of school children classified as mentally retarded and learning disabled.

Table 1

Percent of School Children
Classified as Mentally Retarded and Learning Disabled
Under Education for All Handicapped Children Act Since 1976-77

	% Total Population MR	% Total Population LD	% Special Ed. Pop. MR	% Special Ed. Pop. LD
1976-77	2.16	1.80	26.0	21.5
1977-78	2.14	2.21	24.9	25.7
1978-79	2.12	2.66	23.2	29.1
1979-80	2.09	3.06	21.7	31.9
1980-81	2.02	3.57	20.0	35.3
1981-82	1.96	4.05	18.7	38.6
1982-83	1.91	4.39	17.8	40.9
1983-84	1.86	4.62	16.9	42.0
1984-85	1.84	4.72	16.4	42.2
1985-86	1.68	4.73	15.3	43.1

Source: Data for years 1976-77 through 1983-84 are from National Center for Education Statistics, The Condition of Education (Washington, D.C.: U.S. Department of Education), Table 4.1, p. 1982). Data for years 1984-85 and 1985-86 are from Office of Special Education and Rehabilitative Services, Ninth Annual Report to Congress on the Implementation of the Education of the Handicapped Act (Washington, D.C.: U.S. Department of Education, 1987), Table 2, p. 5. All percentages reflect data for children ages 3-21 in the 50 states and the District of Columbia.

Table 2

Percent of Children Served as Mentally Retarded and Learning Disabled Under Chapter 1 of ECIA (SOP) and EHA During School Year 1985-86 by State

State	% MR	% LD
Alabama	4.70	3.88
Alaska	0.65	6.55
Arizona	1.10	5.29
Arkansas	3.16	5.05
California	0.65	5.11
Colorado	0.81	3.93
Connecticut	1.13	6.38
Delaware	1.79	8.02
District of Columbia	1.59	3.50
Florida	1.76	4.26
Georgia	1.73	2.22
Hawaii	0.77	4.26
Idaho	1.51	4.37
Illinois	1.60	5.14
Indiana	2.35	3.47
Iowa	2.47	4.41
Kansas	1.50	3.97
Kentucky	3.02	3.40
Louisiana	1.52	4.23
Maine	2.18	4.78
Maryland	1.08	6.59
Massachusetts	3.57	5.86
Michigan	1.39	3.77
Minnesota	1.79	5.32
Mississippi	2.44	4.83
Missouri	2.23	5.16
Montana	0.89	4.90
Nebraska	1.85	4.56
Nevada	0.65	5.12
New Hampshire	0.70	5.99
New Jersey	0.79	6.41
New Mexico	0.89	4.54
New York	1.19	5.49
North Carolina	2.19	4.40
North Dakota	1.53	4.34
Ohio	2.84	3.98
Oklahoma	1.97	4.61
Oregon	1.00	5.66
Pennsylvania	2.56	4.38
Rhode Island	1.00	9.44
South Carolina	3.07	3.89
South Dakota	1.36	3.99
Tennessee	1.88	5.31
Texas	0.93	4.98

State	% MR	% LD
Utah	0.93	4.98
Vermont	2.43	4.64
Virginia	1.59	4.72
Washington	1.18	4.59
West Virginia	2.76	4.88
Wisconsin	1.62	3.90
Wyoming	0.83	5.08
50 States and D.C.	1.68	4.73

The figures represent children 0-20 years old served under Chapter 1 of ECIA (SOP). Number of children served is a percent of the students enrolled in Fall, 1985 (Pre-kindergarten-Grade 12). State enrollments are estimated by the Center for Educational Statistics. Data as of October 1, 1986.

Note the variability in the rates of the percent of children classified as mentally retarded and learning disabled; rates ranging from over 4.00% in Alabama for mental retardation to many states under 1.00%, while rates for learning disabilities go as high as 9.44% in Rhode Island.

Variability in the Prevalence of Mild Mental Retardation

As noted above, variability in the prevalence of mental retardation has long been noted. Of importance to the present discussion is the fact that prevalence rates have been higher for (1) school-age children, (2) males, (3) lower socioeconomic status children, particularly during school age, and (4) certain ethnic minority groups (i.e., black, Hispanic). The variation that has led to the most controversy has been the disproportionately high enrollments of black and Hispanic students in programs for EMR children.

Using the Abramowicz and Richardson (1975) figure of 0.4% of the population as having IQs under 50, one can get a rough estimate of the percent of school children in each state who are EMR by subtracting this 0.4 from the total percentage of children served as "mentally retarded" shown in Tables 1 and 2. However, this provides a very crude estimate and one must be cautious even when applying state figures to school districts within a given state. The reason for this is that prevalence tends to be higher in those geographic areas of a state where pockets of poverty exist, particularly when this poverty area contains minority group families. The higher prevalence of mild mental retardation in populations of poor minority peoples has made it difficult (and sensitive) to attribute this prevalence to poverty, ethnicity, or the interaction of the two. It is clear that this higher prevalence among minority students served as a major focus of the challenge to special education in the 1970s.

In California in 1969, 8.9% of the total school population was black and 15.2% was Spanish-surname. That same year, 27.1% of the students identified as EMR in the state were black and 28.2% were Spanish-surname students (Simmons & Brinegar, 1973). Such figures of disproportionate minority enrollments in EMR programs were central to the plaintiff's cases in Diana v State Board of Education (1971) and Larry P. v Wilson Riles (1971). The judge in whose court both cases were heard, Robert

Peckham, was apparently convinced that these disproportionate enrollments were largely due to thediscriminatory nature of intelligence tests administered after children were referred by teachers for learning difficulties. This position has been advanced by Mercer (1973) when she concluded that "Children of all ethnic groups were referred in their approximate proportions" (p. 111). If so, it followed that the reason for disproportion had to come between teacher referral and actual placement -- during the psychological evaluation. Gordon (1980) has faulted Mercer's conclusion, noting that she failed to differentiate those referrals where suspicion of giftedness and learning disabilities, notoriously "white" categories, were combined with those referred for suspected mental retardation.

Reschly (1985) argued that it was not overrepresentation, per se, that gave rise to criticism of EMR programs. He reasoned that the overrepresentation of black children in other programs (e.g., Head Start, Follow Through, Chapter 1) has been neither criticized nor litigated. Rather, it was the combination of overrepresentation coupled with stigma associated with the EMR label and perceptions of poor quality education that precipitated the challenge to EMR programs. Unquestionably, the undercurrent of possible hereditary bases for racial differences in intellectual ability increased the emotional responses of the critics.

Reschly (1985) has also called for a distinction between (1) the percent of EMR enrollment by group and (2) the percent of a group in EMR programs in an effort to understand the magnitude of overrepresentation. He illustrated with data from California where in 1968-69, black students constituted approximately 9% of the school population and slightly over 25% of the EMR enrollments. Yet, only about 3% of black children were classified as EMR. His analysis of data from other parts of the country (e.g., New Jersey, Office of Civil Rights data) supported his point that despite high percentages of the EMR population being black, the percent of black children classified as EMR is extremely low.

Changes in Proportions Since 1970

As noted previously, the Diana case led to the decertification of between 11,000 and 14,000 EMRs in California. Yet, Lambert (1981) reported that despite a drastic reduction in the absolute number of children classified as EMR, this decertification program and the institution of new criteria for eligibility had relatively little impact on ethnic disproportion. Table 3 shows the percentages of enrollments in EMR programs for three ethnic groups for years preceding and following the imposition of an intelligence test moratorium arising out of the Larry P. case. Essentially, the moratorium coupled with new criteria and a lower IQ cut-off, resulted in fewer minority and majority children enrolled in EMR programs. However, the disproportion remained in about the same magnitude. More recent evidence from California suggests that the disproportion has continued. Special Education Pupil Count data for the 1981-81 school year the categories mentally retarded and learning disabled revealed that black children constituted 17.5% of the former group and 13.8% of the LD category, while comprising only 9 to 10% of the school population.

The problem of overrepresentation of minority children in EMR programs has been reported nationally (e.g., Heller, Holtzman & Messick 1982; Polloway et al., 1985). In New Jersey, black children constituted 17.8% of the public school population, yet 43% of the students identified as EMR in that state (Brady, Manni, &

Winikur, 1983). Smith (1984) reported that in five Ohiocities there were three black students assigned to EMR programs for every white student. The data reported by the Comptroller General (1981) suggests that overrepresentation of minority children in EMR programs continues despite full implementation of PL 94-142 and its provisions for least restrictive placement, parental involvement, and nondiscriminatory testing.

Table 3

Proportion of EMR Children of Three Ethnic Groups for Selected Years in California

Year	%Black	%Caucasian	%Hispanic	Total
1969[a]	27.10	43.10	28.10	55,519[a]
1973-74[b]	24.56	50.86	22.74	35,110[a]
1974-75[b]	22.61	53.35	22.20?	
1975-76[b]	24.75	50.89	21.93?	
1976-77[b]	25.43	49.54	22.44?	
1977-78[b]	23.22	51.66	22.64	19,370

[a] Figures in this row and total for 1973-74 based on Simmons and Brinegar (1973).
[b] Figures in these rows based on Lambert (1981).

A major effort to examine minority overrepresentation in special education was reported in a National Academy of Sciences (NAS) Panel Report (Heller, Holtzman, & Messick, 1982). Office of Civil Rights data from 6,040 school districts throughout the nation were analyzed for 1978. Racial or ethnicity disproportion was found to be a national phenomenon, however regional variation was dramatic - southern states were consistently high in disproportion while it did not appear to be a problem in Northeastern or Midwestern states. Furthermore, racial disproportion was highest in districts with enrollments over 30,000 students (i.e., larger districts). Nationwide statistics revealed that the proportion of Hispanic students in EMR programs was slightly lower than that of whites. However, in 26 of the 31 states having 10 percent or more minority enrollments the Hispanic proportion in EMR was higher than for whites. EMR enrollments were further found to contain a disproportionately high number of males, a difference of much greater magnitude in EMR compared to TMR programs. Regional variation in gender of EMR students did not show the differences that were reported for race or ethnicity. This large scale analysis confirmed the ethnic disproportion reported in more regional studies, identified regional differences, and reported variation by gender.

EMR in the 1960s

It is instructive to examine the research literature on EMR (or students with mild mental retardation) during the two periods under consideration. Why has the amount of research on mildly retarded individuals diminished so dramatically over the intervening years (Bartlett, 1979; Haywood, 1979)? Several possible reasons exist, among which are the following:

1. The old EMR population attracted those interested in cognitive psychology because it contained many children functioning at cognitive levels which permitted using traditional learning tasks employed with nonretarded populations.

2. The same psychologists studied subjects with mild mental retardation as a means of studying normative development, and to test general theories of learning and development. Individuals who were mildly retarded were seen as differing in degree, rather than in kind, when theory testing was undertaken. Sometimes, the validity of theories explaining the behavior of persons with mental retardation was tested.

3. Due to the disproportion of poor minority children in the EMR population, they attracted those interested in examining the impact of poverty as a possible causal agent in developmental retardation.

4. The EMR population was viewed by many as containing at least two subgroups of children: genotypically retarded children and a phenotypically retarded group who were genotypically normal. The conventional tests of intelligence and related measures were seen by these investigators as failing to differentiate these two subgroups.

The research literature on mental retardation published in the 1960s and early 1970s abounds with studies comparing EMR samples with nonretarded samples in efforts to understand differences in attentional, verbal learning, memorial processes, use of mnemonics, and the like (see Ellis, 1963, for reviews of much of this literature). Furthermore, findings from these studies were used to test cognitive theories (e.g., Piagetian theories) and to formulate theories specific to persons with mental retardation (e.g., Ellis' Stimulus Trace Theory). Ultimately, leading spokespersons engaged in lengthy debate concerning individuals with mild retardation (i.e., cultural familial mental retardation). This debate was referred to as the "developmental-difference controversy" (Zigler & Balla, 1982). The point to be emphasized is that the old EMR population was of interest to leading research psychologists due to the fact that the population contained substantial numbers of children who cognitively resembled their nonretarded peers. As a result, considerable insight was gained into how these children processed stimuli cognitively and how they differed from their nonretarded peers.

A frequent comment heard from observers in EMR classrooms during the 1960s was that a certain number of these students who were admittedly limited in their

mastery of school subjects were nevertheless "streetwise." Furthermore, many of those students who were seen as streetwise (sometimes referred to as the "six-hour retarded" because they were considered "retarded" only during school hours) were poor minority children. Given the prevalent notions of the 1960s concerning the relative importance of environment in determining intellectual development, other scientists saw this poor segment of the EMR population as a promising group with which to examine the malleability of intelligence via early intervention. During this era, extensive intervention projects were initiated with the intent of preventing developmental retardation.

The observation that EMR programs contained two types of children led to experimental efforts to separate the "truly retarded" (i.e., genotypically retarded) from the "apparently, but not really, retarded" (i.e., phenotypically retarded). A variety of evaluation and assessment procedures were tried with varying degrees of success. For example, Budoff (1967, 1970) used gains (or no gain) on Kohs block tasks following instruction as an indication of those children capable of higher level performance. Jensen (1970) studied the utility of performance on laboratory learning tasks requiring different processes (referred to as Type I and Type II) for differentiating the two separate groups. Mercer (Mercer & Lewis, 1977) devised an elaborate assessment package (System of Multicultural Pluralistic Assessment - SOMPA) in an effort to provide a more culturally unbiased evaluation for children. All of these investigators sought ways of differentiating the population of students with mild mental retardation, and thereby avoiding erroneous classification.

The foregoing illustrates how much research activity in the field of mental retardation was conducted during the 1960s and early 1970s. In fact, much of our understanding of the cognitive and learning characteristics of the mentally retarded population is based on investigations where the sample had mean IQs close to, or exceeding, the current upper limit for defining mental retardation (Grossman, 1983). To illustrate just how drastically things have changed, one need only consider Edgerton's classic follow-up study (Edgerton, 1967) of residents of Pacific State Hospital who had successfully rehabilitated and lived in the community. The mean IQ of the 110 original subjects was 65! The average IQ of institutionalized residents successfully released into the community was within 5 points of the upper limit for mental retardation today! Obviously, caution must be exercised in extrapolating from findings of research conducted during the 1960s to today's population. Current residents of institutions function at much lower levels than Edgerton's subjects, and the experiences encountered in the community by Edgerton's subjects were far different than what awaits the more debilitated individuals who are released into the community today. Similarly, extrapolating from research conducted on EMR samples in the 1960s to today's EMR population is every bit as hazardous. Polloway and Smith expressed it in the following passage: "A significant change in the population served under the EMR label and, in a sense, a redefinition of the term mild retardation has coincided with decreasing interest in this field" (1983, p. 149). How is the EMR population of today different? Let us consider this question.

Fewer in Number

The children in EMR classes today continue to overrepresent black children, despite an overall reduction in the total number of children identified as EMR. Hence, one comparison suggests that EMR enrollments have shrunk

dramatically; that is, there are fewer students receiving special educational services under the EMR label. One important question to which we will return concerns the educational plight of those children who are no longer EMR-eligible due to shifts in definition and criteria for eligibility.

Generally Lower Level of Functioning

A most obvious change in EMR characteristics that accompanied the change in definition is that the average ability level of children in EMR programs today is lower than it was in the era when IQ 85 was the upper cut-off for eligibility. MacMillan, Meyers, and Morrison (1980) described what happened in California in the decade following 1969:

> The result of activities since 1969 is a depletion of EMR classes, with EMR openings filled by some children more severely debilitated, who in the past would have been programmed in classes for trainable mentally retarded (TMR) students..." (p. 111)

Additional support for this belief comes from Polloway and Smith (1983) who noted that the pattern for EMR classes serving children who are identified as culturally familial mentally retarded and who lack a specific pathological cause for their retardation has changed. Increasingly, EMR programs are serving children with Down Syndrome, and children who prior to public school enrollment were served in TMR preschool programs. This latter points suggests diagnosis occurring at an earlier age than was common for mild retardation in the 1960s. Absent from many EMR classes today are those streetwise students described by some as six-hour retarded children during the 1960s.

MacMillan and Borthwick (1980) reported on 151 EMR students attending school during the 1978 and 1979 school years, after the Diana and Larry P. cases had been tried in California. The authors argued that many professionals advocated educational treatments of these children in 1978 based on their impressions of the abilities of children attending EMR classes in 1960. That is, some professionals assumed there were no differences between the population of 1969 and that of 1978. As such, mainstreaming was being advocated extensively. However, in 1978 only 12 of the 151 students were mainstreamed, and in 1979 only 27 (although 9 of this 27 had been reclassified as "normal" before the 1979 school year began). We discounted the possibility that the schools were not complying with the least restrictive environment principle of PL 94-142 because of the trepidation evident in California school administrators for doing anything that could lead to a court case. Rather, we concluded that the most plausible explanation for the relative lack of mainstreaming (particularly for academic instruction) pertained to the degree of disability manifested by the 1978-79 population. "We concluded that [in] the judgment of those responsible for developing the Individual Educational Plan (IEP), the EMR population studied was 'unmainstreamable'" (MacMillan & Borthwick, 1980, p. 157).

Further support for the lower general achievement came from a survey of EMR teachers following the massive decertification of this population in California (between 1969-72). These teachers reported that the children remaining (i.e., those not decertified) were more patently disabled, in need of intensive individual instruction, and unable to profit from group instruction (Meyers,

MacMillan & Yoshida, 1975). In yet another observational study of more than 900 children with mental retardation, few significant differences between EMR and TMR classrooms in actual on-task behavior were noted (Forness, Guthrie, & MacMillan, 1981). A survey by Polloway and Epstein (1985) of professionals and authors in special education revealed that they also saw a need for evidence on the characteristics of the "new EMR" students currently enrolled in programs. Current data (i.e., since the more restrictive definition) describing the characteristics of these children are simply lacking.

One reason for the appearance of greater numbers of children with known etiologies (e.g., Down Syndrome) in EMR classes is evident in California. California decided to combine several mild disability categories (EMR, LD, BD) into a single Learning Handicapped (LH) category, and to combine TMR, severely emotionally disturbed, and severely and profoundly mentally retarded categories into one Severely Handicapped (SH) category. Parents of Down Syndrome children, who had not previously objected to TMR programs for their children suddenly sought to avoid the SH designation for their children and pressed for enrollment in the LH program.

The description of children and adolescents in EMR programs provided by Polloway, Epstein, Patton, Cullinan, and Luebke (1986) illustrates these changes in characteristics of students in EMR programs. Among the findings reported was that gender and racial disproportions continue (more males and blacks). Consistent with the MacMillan and Borthwick (1980) finding, very few students spent a significant proportion of their school day in mainstream settings. As one would predict, if recent students in EMR programs are more debilitated, Polloway et al. (1986) found that the younger children in their sample "were identified virtually at the initiation of their school careers" (p. 7). The average age of initial identification was 5 1/2 years for the younger sample as compared to average ages of 7 1/2 years for males and almost 8 years for females in their older sample. Further, the average IQ for the younger subjects was somewhat lower than was true for the older sample.

Gottlieb (1981) wrote, "the category of EMR appears to be reserved for the lower end of the EMR IQ range usually for children having an IQ of about 65 or lower" (p. 124). What limited evidence exists on the characteristics of the new EMR consistently supports Gottlieb's point and the contention that those being served are functioning at considerably lower levels than did their 1960s counterparts. Further, the EMR category now contains a substantial number of children with known, or suspected, biomedical etiologies which was relatively uncommon in the earlier period. The current stereotyped "EMR student" appears to be identified prior to entering school or immediately upon entry. The more common pattern in the 1960s was for the child to enter school as a normal student and be referred and evaluated after spending a couple years in regular school programs with more modest interventions attempted to accommodate their academic difficulties (Mercer, 1973).

Validity of our Knowledge Base

MacMillan et al. (1980) questioned the validity of the research base, developed during the 1960s and 1970s, for "new EMR" children. They further suggested that findings in the mild mental retardation literature must be interpreted in light of the time-frame in which the sample was secured. As they noted, "for example, many of the children in a mildly retarded sample in a study conducted

in 1965 would be 'nonretarded control' subjects today if they achieved an IQ of 75 to 85" (MacMillan et al., 1980, p. 112). Due to changes in population parameters one must be cautious extrapolating from this earlier research base when considering how children in EMR programs compare to nonretarded children on attention, verbal mediation, metacognitive processes, memory, and a host of other cognitive and learning variables. Maybe more importantly for the present discussion, the time-period specific validity of educational evaluation findings may be of little relevance for current educators. This issue will now be discussed.

Educational Programming for EMRs.

Most populations of exceptional children require educators to modify HOW the children are to be taught. That is, with children having sensory impairments or physical disabilities the educator must present learning tasks and require responses to those tasks which accommodate the sensory or physical impairment. This is also somewhat true for LD children, as well. However, for children who are mentally retarded educators modify both WHAT and HOW the child is to be taught (MacMillan 1982). Educators have limited time to work with children. They must decide how that limited time can be most efficiently spent in order to affect the best result for that child when they exit the school as an young adult. In the early 1960s, EMR programs often did have a sequenced curriculum with specified objectives stressing personal, social, and vocational competence; academic tool subjects tended to be taught in the context of daily living and vocational applications. While Judge Peckham, in his opinion regarding Larry P., characterized these EMR programs as "dead-end" classes, the empirical evidence simply did not support such a clear-cut conclusion (MacMillan & Meyers, 1980).

While the efficacy studies have been criticized methodologically, one study (Goldstein, Moss, & Jordan, 1965) has been generally regarded as well-designed. Children randomly assigned to regular and special classes following kindergarten were compared over a four year period on achievement and adjustment. The authors then conducted a secondary analysis by separating the experimental (i.e., special class) and control (i.e., regular class) subjects into subgroups with IQs above or below 80. This procedure has been criticized (Guskin & Spicker, 1968), but the findings are so cogent to the present discussion that they are presented with a caution to the reader to interpret them tentatively. Goldstein et al. (1965) found that for those subjects with terminal IQs above 80, achievement in the regular class was superior. For those with terminal IQs of 80 or below, however, achievement was superior in the special class. Since students in today's EMR programs have IQs of 70 or below, it would be interesting to re-examine the old EMR curriculum with its emphasis on personal, social, and vocational development in contrast to the more common recent emphasis on narrower academic subjects.

The question of WHERE to educate children identified as EMR preoccupied the field for far too many years. The National Academy of Sciences panel (Heller, et al. 1982) rightfully focused upon the kind of instruction provided students rather than the setting in which instruction is delivered. Whether individualized education plans insure the proper curricular emphasis is doubtful, as the IEP provided a procedural step but cannot insure good judgment. Given the change in population characteristics of students labeled EMR, it is time for attention to be devoted to re-evaluating the appropriateness of WHAT and HOW these children are to be taught. Is the current academic emphasis appropriate? Which new "EMR" children, and under what

conditions can they be successfully mainstreamed? Some of these questions are empirical in nature and call for research. Others are more philosophical and require careful consideration by those best qualified to insure that what we do is right for these children and not simply expedient.

The concerns raised thus far focus on what is best for the children remaining in the EMR category. However, the changes that have taken place indirectly affect that segment of the school population that would have been eligible for EMR services under the more inclusive definition of the 1960s. What has happened to the present day counterparts of these higher functioning students during the 1960s? We will now turn our attention to this group.

Marginal Learners: IQ 75 to 85

At the time special education for EMR children was challenged in the literature and in the courts, the critics never denied that the children in question were having academic difficulties. Rather, they questioned whether the children were really retarded, and whether the instruments used in the diagnosis were discriminatory against certain racial and ethnic groups. Other questions challenged traditional EMR programming. With the court actions, passage of PL 94-142, and changes in the AAMD definition to a lower IQ limit, a substantial number of children were deemed ineligible for EMR programs. MacMillan, Hendrick, and Watkins (in press) observed that most critics viewed these developments as "victories" since the system changed in response to the challenge mounted. However, few have returned to examine whether these changes have had effects on the children continuing in EMR programs, the group referred to as marginal learners (no longer eligible), or the regular class students into whose classes the marginal students have been placed. We focus here on only one of these groups - the marginal learners.

As part of a federally funded project, this author along with colleagues (C. Edward Meyers, Roland K. Yoshida) studied students decertified as EMR and returned to regular classes following the Diana decision. For comparative purposes, we contrasted this group of decertified students with a sample of children who had remained in regular grades throughout their schooling, but who had achieved consistently in the lowest quarter of their classes. On standardized achievement tests, the decertified group achieved significantly lower than this low-achieving regular class sample. Further, their level of achievement was several years below the grade level at which they were placed. The general pattern which emerged for the decertified children was, at best, a marginal educational existence in regular grades.

With the dramatic increase in LD enrollments over the past 10 years, one might speculate that the no longer eligible segment of the old EMR population are having their special educational needs met in LD programs rather than EMR programs. However, a number of authors (e.g., Forness, 1985; Forness & Kavale, 1984; Polloway & Smith, in press; Smith, Polloway, & Smith, 1978) have concluded that the current students with IQs between 75-85 reside in an educational "DMZ," or "no man's land" where students are ineligible for any special educational services. The reason is that the identification of learning disabilities usually requires a demonstration of a "severe discrepancy" between aptitude and achievement. With IQs in this range, it becomes difficult to establish a discrepancy, since low achievement can always be explained in terms of the low IQ. As Forness (1985)

wrote: "It is therefore quite possible that children with IQs in that general range might never qualify as LD, no matter how low they score on achievement measures" (p. 39).

What appears to have happened to the "old EMRs" with higher IQs, the present day marginal learners, is that they are enrolled in regular education programs in great numbers. As MacMillan et al. (in press) noted, this is viewed as desirable from the perspective of those who argued they had formerly been inappropriately placed in special education and labeled EMR. However, the very real low achievement which led to their certification in the 1960s was not caused by intelligence tests or labels -- it preceded evaluation and labeling. How are these children, who have avoided labeling and special education placement faring educationally? Are their achievement problems addressed while in regular grades and are they performing as "normal" students?

Equality vs. Excellence

MacMillan et al. (in press) contrasted the influences that led to Diana, Larry P., and PL 94 -142, which they referred to as a press for equality, with the current push for excellence exemplified in the report of The National Commission on Excellence in Education (1983). During the late 1960s and early 1970s criticism abounded regarding the discrimination and inequality inherent in special EMR classes for minority group children. The reasoning went that the achievement and adjustment of these children was detrimentally affected by labeling and segregation into special classes. Hence, the move to get these children decertified was advanced as promoting more equal educational opportunity for these children. Largely through the courts and legislation, this goal was accomplished.

During the early 1980s, however, another force has emerged in public education, promoting a return to basics and high standards. The report, A Nation at Risk, expressed outrage at the lack of standards in public education. High school diplomas were portrayed as meaningless because recipients frequently were barely literate. The Commission, which deplored the smorgasbord of electives that pervaded American schools during the 1960s and 1970s, called for an upgrading in standards and a return to basic academic subjects. One manifestation of the press for excellence has been the passage of legislation in some 40 states requiring minimum competency tests (MCTs), frequently required in order to graduate from high school. Let us consider the effects of this press for excellence as it affects the educational careers of the educationally marginal learners, who will be held to these newer and tougher standards.

The higher functioning students in the EMR programs of the 1960s were believed to be afforded better educational opportunity in regular programs than in special EMR programs. However, even the most ardent advocate for this group of children did not deny their educational problems. Rather, the belief was that, on balance, they would fare better as adults having been exposed to the regular school curriculum and interacting with nonhandicapped peers than they would fare were they to continue in the EMR program. No one suggested that future valedictorians would come from their ranks, and "better achievement" in the discussions of the times suggested reliable differences compared to achievement in special classes, but not at or above grade level. It is instructive to note that in a review of mainstreaming literature, Semmel, Gottlieb, and Robinson (1979) reported

that the highest mean reading achievement test score reported for students identified as EMR, regardless of age or setting in which they were taught, was 3.8. However, with the advent of the press for excellence, the anticipated benefits for the marginal students were confronted by policies that would not tolerate mediocrity and required excellence (although MCTs require minimal standards they are viewed as consistent with the press for excellence). These students find themselves confronted with standards for graduation that they are ill-prepared to meet. Ironically, most states do have provisions for students enrolled in special education programs whereby they can meet the MCT requirement by either taking tests under modified conditions or by fulfilling the IEP. However, any student not in special education must meet the existing standard by passing the test administered under standardized conditions.

This author is currently engaged in a project studying the MCTs in California as they are used with students who are mildly handicapped or educationally marginal. What is apparent in reviewing achievement data for the marginal students is the extraordinary number of 8th grade students who are achieving in the first through fifth percentile and have never been referred for special education evaluation. How does a student get promoted through all elementary grades and well into junior high school when they are reading at a second grade level? One gets the distinct impression that social promotion is the order of the day for these students, and one must be pessimistic regarding the chances of these students to ever get a high school diploma given the requirement that they must pass the MCT.

The long-term consequences of whether marginal students are currently (in light of press for excellence) better served in regular programs or special education programs needs serious consideration. For example, one development we have found in the MCT project is that the high schools are having to provide remedial classes for students who fail to pass the MCT subtests--that is, a student who fails the reading subtest in 8th grade is enrolled in remedial reading during 9th grade. For the marginal students, MCT failures are most common and they are enrolling in the remedial classes, thereby denying them the opportunity to enroll in electives. Yet, the electives are the very courses which prepare them for employment upon leaving high school. The course sequences taken by these students consists of those courses required for graduation with "open" periods being used to take the remedial classes. Electives are rapidly diminishing in these high schools, due to a lack of demand. The college bound students, who pass the MCTs early, are not opting to take them. The non-college bound students, who would take the courses, do not have the opportunity to take them due to remedial courses required upon failure of the MCT.

It is unclear to us at this time whether the MCTs are implicated in the escalating dropout rate in high school. The Committee on Policy Research of the California Assembly reported the following:

> Students drop out because they are not succeeding in school, they want to work, or they are pregnant...Some dropouts fail district proficiency tests or courses required to graduate. Of the 100,000 dropouts in the class of 1983, 41,000 left in 12th grade due to failure of proficiency tests or the courses needed to graduate. (1985, p. iii)

This same report documents the increase in the number of dropouts during 12th grade. Previously, the sophomore and junior years were those when dropouts most

frequently made the decision to leave school early, but once enrolled in 12th grade fewer students decided to drop out. However, it may be that with the advent of MCTs, more marginal students only become aware that they either have not made sufficient academic progress to graduate at the end of the year, or it becomes apparent to them that the chances of them passing the MCT are poor. Then, they drop out because they are not going to graduate as anticipated in the following June. We cannot say with certainty at this time whether the marginal students constitute a disproportionately high number of high school dropouts. However, we will be gaining some insight into this possibility during the course of the project.

It is clear to this writer that far too little is known about the educational plight of these marginal students. MacMillan et al. (in press) cautioned that we must not assume that their educational/personal careers are automatically successful just because they are no longer labeled and segregated. These authors reviewed evidence suggesting that little improvement has occurred in the quality of education received by these students. No matter what they are called or in what setting they are taught, these children represent a group that educators have not been successful in reaching. It appears unfortunate that interest in, and the study of, this group has diminished. By not qualifying for special education, these children appear to lack the advocate support of professional organizations such as the Council for Exceptional Children and the American Association on Mental Deficiency. At present, this support is clearly lacking as the attention of professionals in those groups has shifted to different populations such as students with learning disabilities and children who are more severely handicapped.

SUMMARY

It is apparent from this review that there has been a reduction in the absolute number of children served in EMR programs between 1960 and the present. Moreover, it is apparent that the current EMR group is a more patently disabled group, including some sizeable number of children who would most likely have been enrolled in TMR programs during the 1960s. The changes ought to prompt increased research and evaluation efforts designed to more carefully describe the behavioral characteristics of those children enrolled in these programs. What are they like? What are they capable of learning? Do they present behavior problems in addition to the academic problems? Descriptive information would be welcomed, but thus far very little of it has been forthcoming despite the fact that it is apparent that they are a different subset of children than those studied extensively during the 1960s and 1970s.

Once we understand the population parameters defining this current group, it seems desirable to seriously consider how their years in school can be best spent to achieve the best result upon leaving school as young adults. We should not automatically accept the "back to basics" notions for these children without giving serious consideration to traditional EMR objectives of personal, social, and vocational competence. At this point, it appears that the curricular decisions that must be made on behalf of these children cannot be made in an informed fashion--the necessary evidence is simply lacking.

Finally, we ought not worship IQ cut-offs for deciding either which children belong in, or out of, EMR programs. The recent AAMD recommendation (Grossman,

1983) permits IQs up to 75 in order to clearly communicate to users that IQ is to be used as a guideline and not an absolute value. Nevertheless, an arbitrary (although reasoned) decision was made to drop the IQ cut-off, thereby excluding from eligibility a large group of children formerly served. This writer would hope that those who had previously taught, studied, and advocated for these children would not simply forget them. They need our attention as much, or more, than they have in the past.

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